ARTICLE 12

SECTION 1

DETERMINATIONS

1. GENERAL

This section clarifies regulations and provides instructions for determining the share-of-cost for all Medi-Cal Family Budget Units (MFBU). This section also establishes procedures to follow when changes increase or decrease the share-of-cost. The share-of-cost is the amount the MFBU must pay or obligate to the Medi-Cal provider before the issuance of a Medi-Cal card can be authorized. The share-of-cost is determined at time of application, reapplication or restoration, and when there is a change in income, family composition or any other situation affecting the share-of-cost.

2. DETERMINING THE SHARE-OF-COST

In most Medi-Cal cases the share-of-cost is determined on MACB using income figures from the Medi-Cal budget worksheet (Form 14-29 DSS) or the Allocation/Special Deduction worksheet (Form MC 176W). For cases that are not on MACB, Forms MC 176M and MC 176M-LTC are used for manual share-of-cost computations. MEM 50653

The share-of-cost is determined as follows:

A. Non-LTC MFBU's

1) Determine the net nonexempt income available to the members of the MFBU. (Round the total net nonexempt income to the nearest dollar with amounts ending in $.50 or more to the next higher dollar.)

2) Determine the appropriate maintenance need for the MFBU. (Refer to MPG Article 11, Section 1, Appendix A.)

3) Subtract the maintenance need from the total net nonexempt income. The remainder, if any, is the share-of-cost.

B. For LTC MFBU's

1) Determine the total countable income available to members of the MFBU.

2) Add to the total income any income amounts previously deducted in accordance with MPG Article 10, Section 2.

3) Subtract from the amount determined in 2) the deductions and allocations specified in MPG Article 10, Sections 2 and 3. (Round the total net nonexempt income to the nearest dollar, with amounts ending in $.50 or more to the next higher dollar.)

4) Determine the appropriate maintenance need. (Refer to MPG Article 11, Section 1, Appendix A.)

5) Subtract the maintenance need from the total net nonexempt income. The remainder, if any, is the share-of-cost.

3. CHANGES WHICH DECREASE THE SHARE-OF-COST

When a change in income or other circumstances result in a decreased share-of-cost, the appropriate action to be taken depends on whether the beneficiary reported the change in a timely manner as specified in MPG Article 4, Section 2. MEM 50653.3

A. Beneficiary Reports Change in a Timely Manner

When a beneficiary reports timely, and the reported change will result in a decreased share-of-cost, the worker will:

1) Recompute the share-of-cost for the month following the month in which the change was reported.

2) Determine what the share-of-cost should have been for the month in which the change occurred.

3) Give the beneficiary a choice of either of the following options:

a) Having an adjustment made in future months.

b) Advising the provider of the corrected share-of-cost so the provider may seek payment from Medi-Cal and reimburse the beneficiary. MEM 50653

Examples for adjusting the share-of-cost in future month(s) or revising the share-of-cost are located in MPG Article 12, Section 2.C.

B. Beneficiary Does Not Report Change in a Timely Manner

When a beneficiary does not report timely and the reported change results in a decreased share-of-cost, the worker will:

1) Recompute the share-of-cost for the month following the month in which the change was reported.

2) Not make an adjustment for the excess amount the beneficiary may have paid or obligated toward medical bills unless the beneficiary had good cause for failure to report in a timely manner as specified in Article 4, Section 2.

4. CHANGES WHICH INCREASE THE SHARE-OF-COST

A. Changes Reported in a Timely Manner

When a change in income or other circumstances, which results in an increase in the share-of-cost, is reported timely by the beneficiary, as specified in MPG Article 4, Section 2, the worker shall change the share-of-cost either in a future month or immediately. MEM 50653

1) Future Recomputation

a) If a 10-day notice can be given, the worker will recompute the share-of-cost for the month following the month that the change was reported; or

b) If a 10-day notice cannot be given, the worker will recompute the share-of-cost for the second month following the month in which the change was reported.

2) Immediate Recomputation

If the increase is due to the voluntary inclusion of a family member who has income, which results in a SOC increase for the household, the household's SOC cannot be increased without timely notice of action. The worker will recompute the share-of-cost immediately and follow the appropriate steps detailed below:

a) If the individual being added to the case will be included in the MFBU with other household members, the individual will receive benefits through a separate FBU for the first month of aid or until 10 days notice can be given to increase the household's SOC. When timely notice can be given, the individual will be discontinued from his/her separate FBU and added to the household's MFBU.

b) If the individual being added to the case will be in a separate FBU from other household members, the individual will receive benefits through that FBU with the recomputed SOC.

c) Issue a NOA approving benefits for the newly added family member with the correct SOC for that individual. Issue a second NOA effective the first of the following month indicating the increased SOC for the entire MFBU (as long as timely notice can be given).

B. Changes Not Reported in a Timely Manner

When a change in income or other circumstances, which results in an increased share-of-cost, is not reported timely, the worker will:

1) Increase the share-of-cost in the month following the month in which the change was reported, or the first of the second month following the month in which the change was reported, if 10-day notice cannot be given.

2) Evaluate for a potential overpayment beginning the month following the month the change should have been reported in accordance with MPG Article 16, Section 2. Report the potential overpayment per the previously mentioned MPG section if appropriate. MEM 50653

5. CHANGES IN SHARE-OF-COST DETERMINATION DUE TO ADMINISTRATIVE ERROR

An administrative error which causes the share-of-cost to be in excess of the correct share-of-cost is adjusted in accordance with MPG Article 12, Section 2.C.

6. HUNT V. KIZER: REDUCING SHARE-OF-COST USING PRIOR MEDICAL EXPENSES ACWD 90-11

Persons eligible for Medi-Cal with a share-of-cost (except for state only programs - AID codes 53 and 81) can use prior medical expenses to reduce their share-of-cost.

A. Required Notification

All applicants must be informed of the Hunt vs. Kizer lawsuit. The Medi-Cal pamphlet, "Medi-Cal What It Means To You," provides information on the Hunt vs. Kizer lawsuit. The pamphlet will be provided to all Medi-Cal applicants with the MC 210. Notification is also required at yearly redetermination. MEM Proc. 10-R

B. Criteria For Use

1) Medical expenses that were previously used to meet or to reduce share-of-cost or spend down cannot be used again to reduce SOC.

2) Medical expenses can be for any family member who would have been a member of the MFBU on the date the medical expenses were incurred.

3) The medical expense may be for a non-covered service, which is not subject to payment by the Medi-Cal Program because: MEM Proc. 10-R

   a) The medical service is not covered by Medi-Cal; or

   b) The provider is not a Medi-Cal provider.

4) The applicant must still be legally liable for the medical expenses. A person is considered legally liable for debts if:

   a) The debt is less than four years old; or

   b) There is a judgment; or

   c) There is a contract extending the statute of limitations; or

   d) Any payment has been made on the debt within the last four years; or

   e) There is an agreement to pay on the debt; or

   f) There is other reasonable verification showing the person is still responsible for the debt.

5) The amount of the medical expenses for which a third party is liable (other health coverage) must be subtracted from the amount billed to the beneficiary. MEM Proc. 10-R

6) Medical expenses (or any portion of a medical expense) must be unpaid at sometime in the month the expenses are submitted to the County for consideration. Only the portion remaining unpaid in the month of submission can be applied toward the share-of-cost.

   Note: The worker may consider this requirement satisfied when the bill's date of issuance falls within 90 days of the bill's submission to the County for consideration, unless the beneficiary indicates that the bill has been paid or the worker has reason to believe that the bill has been paid since the bill's issuance date.

7) Persons currently eligible for Medi-Cal with a share-of-cost may request consideration of their old medical expenses/bills that are unpaid (regardless of when they were incurred), to reduce any current or future month(s) share-of-cost,

beginning with the month of September 1989. Beneficiaries cannot designate a month several months in the future. Workers will accept old medical bills for consideration only one month in advance.

8) Persons currently eligible for Medi-Cal may request consideration of their old medical expenses/bills towards a past month(s) share-of-cost, when the expenses meet the criteria for use. Old medical bills used for a past month share-of-cost must have been incurred prior to the month it will be used towards the share-of-cost. The share-of-cost must be met by using the old medical bills or a combination of old medical bills and bills incurred in the past month. The bills cannot be applied toward a past month in which the beneficiary met their share-of-cost. These expenses cannot be applied towards a share-of-cost more than 12 months previous to the month of their submission (months for which a Letter of Authorization would be necessary) unless the beneficiary qualifies for a Letter of Authorization on grounds of Administrative error.

9) Old medical expenses/bills that exceed the beneficiary's share-of-cost for the month in which it is being applied towards, must continue to be applied to the next consecutive month(s).

Note: If a beneficiary submits multiple medical bills for consideration and these bills exceed the share-of-cost for the month it is being applied towards, the worker will advise the beneficiary to submit bills from non-Medi-Cal providers before submitting bills from Medi-Cal providers.

C. Verification of Required Information

1) When a client presents an original bill or an acceptable substitute for consideration, workers must review the billing statement(s) to ensure that required information is provided. If any required information is missing, it is the responsibility of the client to contact the provider for the missing information. The worker must explain to the client what items are necessary in order to allow the bill to be used.

2) If the original bill or acceptable substitute appears to have been altered, the applicant must obtain an unaltered bill from the provider, credit card or collection agency.

An "original bill" means one prepared by the provider of services.

An "acceptable substitute" is an original credit card billing statement, collection agency billing statement or other written billing statement from a provider. All qualifying and verification requirements must still be met and the client must provide documentation that the medical expense was not paid prior to the month of submission. Photocopies of credit card or collection agency statements may be accepted if signed, initialed, or signature stamped by the manager of the account who has legal authority to represent the billing organization. ACWD 93-63

3) Required items are:

a) Billing date not more than 90 days prior to the date the bill is received by the County for consideration.

b) Provider's name and address

c) Name of the person receiving the service

d) Type of service

e) Procedural code (medical reference number)

f) The provider's federal tax ID number, or provider's license number, or Medi-Cal provider ID number.

g) Date of service

h) Amount owed in the month for which it is being used to meet the SOC.

4) Documentation of Unpaid Bills

a) When reviewing the medical bills to determine if the required information is included, note on each original/acceptable substitute bill either "Accepted" - "Hunt vs. Kizer" or "Denied"-reason code (numbers 1-14) "Hunt vs. Kizer." Denial codes are:

(1) Provider's name or address missing or illegible

(2) Name of person receiving the service is missing or illegible

(3) Type of service not provided

(4) Procedural Code missing

(5) Missing or illegible provider's tax I.D. number, license number, or Medi-Cal I.D. number (only one needed)

(6) Date of service not provided

(7) Billing date not shown/not current

(8) Amount owed not provided

(9) Failure to provide original bill or acceptable substitute

(10) Medical expenses did not meet the SOC

(11) Other (reason must be stated)

(12) Medical expenses were previously used to meet a SOC

(13) Bill does not qualify as a medical expense

(14) Bill was not an unpaid bill

b) When all the necessary information is provided, the worker will make a copy of the bill for the applicant and RETAIN THE ORIGINAL in the case file.

If the client has made an effort but is unable to obtain the information identified in items 1 through 6 above, in writing from the provider, the worker must attempt to obtain the information. If the worker is unable to obtain the missing information from the provider, the client can submit a sworn statement supplying the information. The worker must determine that the beneficiary has knowledge of the information to which he/she attests. This is especially true when the beneficiary attests to the provider's identification number, the procedure code, or the type of service.

D. Processing of Medi-Cal Bills Under Hunt v Kizer

MEM Proc. 10-R

1) Current Bills

Medi-Cal beneficiaries generally have their current medical bills applied towards their SOC by their provider, using the provider's Point of Service (POS) device, at the time they receive medical services. However, as noted previously, under Hunt v Kizer beneficiaries are allowed to use bills for medical services from providers who do not participate in the Medi-Cal Program (and thus do not have POS devices). Therefore, beneficiaries have the option of submitting medical bills for the current month to the County, and have County eligibility staff adjust the SOC for the current month.

2) Old Medical Bills

Individuals must submit to the County old medical bills that they wish to apply towards their SOC. Providers cannot process and apply old medical bills toward the SOC. Only the County eligibility staff can process and apply old medical bills toward SOC.

E. Budget Actions

1) Adjust the share-of-cost for current and, if necessary, future months.

a) Manual budgets - Enter the old medical expenses on MC 176M, Column III, Line 15, Underpayment Adjustment Box.

b) AIS - For cases with valid old medical bills, let AIS determine the budget without using old medical expenses. If the case has a share-of-cost, put in the No Medi-Cal Issue BIC 899, so that share-of-cost information will not transmit to MEDS.

On the turn around document, use BIC 894 to reduce the share-of-cost, and then release the No Medi-Cal Issue BIC.

c) A 10-day NOA must be sent when share-of-cost increases at the end of any adjustment period. ACWD 90-45

2) To adjust the share-of-cost for a past month(s), the worker will: ACWD 93-63 and County procedure

a) Complete a MC 176 M for the past month and enter the old medical expense in Column III, Line 15 Underpayment Adjustment Box.

b) Correct the MEDS share-of-cost record via G-Line or 14-28 DSS form (do not use the spend-down section of the 14-28 DSS).

c) File the original old medical bill(s) used to reduce the SOC under the share-of-cost tab and the MC 176 M in the financial folder.

d) If the old medical bill(s) reduce the SOC to zero, change the aid type on MEDS and CDS to a non-SOC aid type for the past month.

e) Use BIC 894 to reduce the SOC for current CDS budget months.

F. Hunt vs. Kizer Notices

1) If the medical bills are acceptable, send a "Medical Bills Approved Letter," HK App. Letter (NOA code 028), within 30 days from the date the bill(s) is submitted.

2) If the bills are not acceptable, send the client the "Hunt vs. Kizer First Disapproval Letter," HK Disapproval Letter-1 (NOA code 019) and allow the client 10 days to submit additional information or correct the problem.

3) After the client's 10-day period, send the "Hunt vs. Kizer Second Disapproval Letter," MC 239 HK (NOA code 009) with the original bills attached. This notice must be issued within 30 days after the client's 10-day period has expired.

G. Questions and Answers

Question 1:

What is an original bill?

Answer 1:

An original bill is one that is prepared by the provider of medical services. It may not be a photocopy of a bill sent by the provider. An original bill does not have to be the first bill for a service. It may be any subsequent bill or bills so long as it contains the required information and is not a photocopy. ACWD 90-80

Question 2:

What type of secondary evidence is acceptable if the bill lacks the required information necessary for it to be used to reduce a share-of-cost (SOC)?

Answer 2:

Any supplemental bill or statement from the health care provider or the representative of the health care provider (i.e., an attorney or collection agency) that supplies the necessary information may be used. A sworn statement from the beneficiary is acceptable so long as the person can knowledgeably attest to the accuracy of the required information. Example: A beneficiary has adequate knowledge to provide a sworn statement as to date of service, name of the person who received the service, the provider's name and address; he/she does not have sufficient knowledge to swear to the provider's identification number, the RVS code, the type of service or the amount for which he/she is still legally liable.

Question 3:

Is an IHSS SOC an acceptable medical expense to be used to offset a Medi-Cal SOC? What about interest on an overdue bill?

Answer 3:

No. An IHSS SOC is not considered to be a medical expense. Interest is not a medical expense. Only medical expenses may be used to meet a Medi-Cal SOC.

Question 4:

Example:

A beneficiary who is eligible with a $750 Medi-Cal SOC has a $1,400 unpaid medical bill. In December 1988, the Medi-Cal beneficiary agreed to pay the provider $750 and, as a result, used this amount to meet his December 1988 SOC. Nothing has been actually paid on the outstanding balance of $1,400. Can the entire amount of $1,400 be used again to meet an SOC?

Answer 4:

No. Only the amount that was not used to meet a previous month's SOC may be applied under the Hunt v. Kizer provisions. In this example, the unused amount is $650. ACWD 90-80

Question 5:

Under what circumstances must counties accept medical expenses that have been charged to credit cards?

Answer 5:

Credit card charges for medical expenses can be used:

1) If there are no other charges on the credit card and the beneficiary can show that the charge for medical expenses has not been paid. The beneficiary must provide all charge account statements received since the date of the charge.

2) If the beneficiary can show that the charge for medical expenses and all of the charges made to the credit card since the date of the charge for medical expenses are unpaid. All charge account statements received since the date of the medical expenses must be provided.

3) If the medical expenses charged to the credit card are used to reduce the SOC for the month in which the medical expenses were incurred.

   Note: Finance charge may not be used to reduce the SOC.

Question 6:

Can medical expenses that have been turned over to a collection agency be used to meet a SOC?

Answer 6:

Yes, if the original collection agency bill contains all of the required documentation or if a combination of the collection agency bill(s) and other original billings statements supply the missing information.

APPENDIX A

H. **HUNT VS. KIZER**

DEFINITIONS: ACWD 93-63

Current Month: This refers to the current calendar month with respect to the reader. For example, the current month would be whatever month you are in when you read this.

Future Month: A future month is any month which is future to the current month.

Previous Month: A previous or past month is any month which occurred prior to the current month.

Current Medical Bills: The term "current medical bill" refers to a medical bill which is/was incurred in the same month (month of eligibility) for which it will be applied toward the beneficiary's SOC. A current medical bill for the purpose of the Hunt if the bill is applied by the beneficiary toward his/her SOC in the same month in which the bill was incurred.

Old Medical Bills: The term "old medical bill," as used in these Hunt procedures, refers to a medical bill which was incurred in a month previous to the month for which it will be applied toward the beneficiary's SOC.

Month In Which A Medical Bill Is Incurred: A medical bill is incurred on the date the medical service or drug is provided. The month in which a medical bill is incurred is the month in which this date of service falls.

Medical Bills Spanning Two or More Months: In some instances, a medical service, such as a hospital stay, which was rendered over multiple days and therefore shows multiple dates of service. A medical bill showing such a multiple-day medical expense spanning more than one month is incurred in each month containing one or more date of service for that expense. For each example, a medical bill showing a single medical expense for a medical service, such as a hospital bed charge, might show the dates of service as March 27, 1992 through April 7, 1992. This medical expense has been incurred in both March and April.

Unpaid Old Medical Bills: Unpaid old medical bills are old medical bills which are unpaid at some time in the month in which they are submitted to the county (i.e. the old medical bills have not been paid previous to the month of their submission). If a portion of the old medical bill has been paid, the unpaid portion may still be applied toward the beneficiary's SOC.

Medical Bills and Medical Expenses: Medi-Cal can accept for application toward a beneficiary's SOC only medical bills for bona fide medical expenses. Expenses for medically-related services qualify if the service was rendered by a State-Licensed health-care provider.

Expenses for medically-related equipment, supplies or drugs qualify as bona fide medical expense if the equipment, supply-item or drug was:

1. Prescribed by a physician as necessary to treat a medical condition; and

2. Is customarily considered by the medical profession as primarily for health care and medical treatment; and

3. Is intended, and will be used, solely for the health care medical treatment of the beneficiary.

Medi-Cal presumes that medical expenses for drugs and supplies which are available only through a prescription are necessary to treat medical conditions and that expenses for these items are therefore bona fide medical expenses. This does not apply to medically-related equipment, drugs and supplies which a physician has prescribed but which are available without a prescription.